Multi-payer patient-centered medical home stakeholder group

Senator Mike Gloor

Meeting date: Monday, November 16, 2015, 1:30 to 3:30 p.m.

Meeting place: ***Room 1524***, State Capitol Building, Lincoln, Nebraska

Conference Access Number: **(888) 820-1398;** Attendee Code: 1971560#

Contact: Margaret Buck, 402-471-2617; mbuck@leg.ne.gov

Technology note: Any Power Point presentations to be used in reports need to be emailed to mbuck@leg.ne.gov by Thursday, November 12th in order to be preloaded onto Legislative equipment. If handouts are used, please bring at least 35 copies.

Agenda

A. Welcome & introductions

B. Anti-trust statement

C. Update from NEHii

D. Report from subcommittee on health outcomes measures

E. Discussion and vote on health outcomes measures

F. Dialogue and review of proposed 2016 Agreement language

G. Vote on Agreement language

H. Other communication

I. Tentative next meeting date for agreement signing: Friday, December 4, 2015

Senator Mike Gloor
PCMH Stakeholder meeting minutes
November 16, 2015 1:30 pm to 3:30 p.m.
Room 1524, Nebraska State Capitol Building

In attendance:

Senator Mike Gloor, District 35
Senator Mark Kolterman District 24
Margaret Buck, Leg. Aide to Senator Gloor
Dr. Deb Esser, Blue Cross Blue Shield
Gail Brondum, BCBS
Brad Hove, Blue Cross Blue Shield
Dr. Steve Lazoritz, Arbor Health
Dr. Bob Rauner, NAFP
Dr. Matha Arun, Aetna Better Health
Dr. Mike Horn, United HealthCare
Dr. Dale Michels, SERPA
Dr. Tony Sun, United HealthCare
Dr. Carol LaCroix, Aetna
Margaret Brockman, Ofc of Rural Health
Dave Palm, UNMC College of Public Health
Dr. Michael Hein, Enhance Health Network
Jamie Bland, Enhance Health Network
Jina Ragland, NMA
Jon Copley, Aetna Better Health
Chris Stark, Aetna Better Health
Bruce Reiker, NHA
Elizabeth Hurtz, NHA
Will Molitor, Arbor Health
Brad Myer, Peoples Health Center
Christine Moran, Nebraska Academy of Nutrition and Dietetics
Charlene Dorcey, NAND
Robert Bell, DOI
J.P. Sabby, DOI
Sara Hotovy, SERPA
Pat Lopez, Public Health Association
Krissa Delka, Committee Clerk for Revenue Committee
Corinna Suiter, BCBS
Bryson Bartels, NDHHS
Deb Bass, NeHII

A. Welcome & Introductions

B. Anti-Trust Guidelines

C. Update from Nebraska Health Information Intiative, NeHII

- non-profit, 16 member board
- Opt out platform
- By December 62% of hospital beds in State connected, goal of 80%
- Moving to cloud based platform
- 3 million lives in system
- Over 1 M test results available through system
- Behavioral health records are scrubbed from hospital records due to federal code
- Connectnebraska.net is the public access site
- Office of National Coordinator interoperability grant awarded
- High tech 90/10 funding approved by CMS in 2014 for use in 2015, 2016
- State funding to help meet meaningful use requirements and operational expenses for the next two years
- ADT messaging, readmission reporting, enhanced PDMP
- Public health gateway for syndromic surveillance and immunizations
- Currently NeHII is in the beginning stages of population health abilities needed for PCMH with ADT reports/alerts
- Deb Bass - power point presentation attached
- NeHII Fact Sheet pdf on website (nehii.org)
- Transitions of care enabled by the direct secure email
- Future added functionalities:
    - Faster deployment and update, lower ownership costs
    - Data analytics coming
    - More complete prescription medication information
    - Prescription drug monitoring program
    - Community HIT program setting up two integrated communities
    - Next 12-18 months focus: Doctors First, PDMP, data analytics, SDS functionality (state to state exchange for use in national exchange) EHR solution for public access

Q & A

Question: Can NeSIIS interface with NeHII on immunization records; with Medicaid integrating behavioral health, is there any way to integrate those records.

Answer: The challenge is in getting pharmacy sites to join NeHII, challenges in accuracy, working with Division of Public Health to improve.

Question: Behavioral health information?

Answer: In conversations with State but consent issue requires a federal law change.

Question: Explain event messaging. Texting? How to keep from overwhelming provider?

Answer: Flexible options for type and frequency of notifications at the discretion of provider.

Question: How is syndromic surveillance done?

Answer: Currently the system only uses patient records but there are discussions about creating the functionality for public health notifications in the future.

Question: How is NeHii working toward patient registry/attribution of provider and data analytics?

Answer: That data is coming from the HIE so we are working on agreements for information exchange. The new Spectrum tool will be set up by/for each provider in the system.
Question: How do you manage changes of providers and patients?
Answer: That will be based upon policy set by our privacy and security committee that is in process and we found that patients want 1 patient portal to manage, not multiple portals from a variety of health care providers.

D. Report from subcommittee on health outcomes measures
Dr. Bob Rauner gave an overview of the proposed outcome measures the subcommittee suggests for adults, pediatrics and prenatal. (See attachments)

E. Discussion and vote on health outcomes measures
Motion to adopt: Dr. Steve Lazoritz, 2nd: Dr. Deb Esser. Motion adopted unanimously.

F. Dialogue and review of proposed 2016 Agreement language
Senator Gloor gave a history of the legislative side of the Agreement and an overview of changes:
Names changed - Senator Wightman removed (page 1), Senator Crawford & Senator Koltermann names added (page 3)
Dates changed - 2 year agreement and current years adjusted (page 1)
Term change - "Participation Agreement" (page 2), Progress report language change (page 2)
Dates/timeframe to publish annual report - January 1 of the following year. 11-12 months of data compiled for annual report. To be available in December.

The definition of PCMH included the change from "physician-directed team" to "primary care practice team" because of the current changes in state law and to add some flexibility.
Discussion: The change in definition could risk approval by SERPA ACO and possibly the Nebraska Academy of Family Physicians.
Answer from Sen. Gloor: This ultimately comes down to the provider and the payer/health insurance company. As an example, the Nebraska Medicaid contracts allow for independent practice nurse practitioners to serve as a PCMH, without any deference at all to this agreement.
Discussion: A report of information gathered about national accrediting organizations' definition and policy in regard to NPs and PAs as well as the definitions used in other state programs with multiple payer structures. Debate followed on the definition change.

Margaret went over suggested changes for consistency in the names of the health outcomes and the information to be reported by payers under this Agreement and the addition of the anti-trust statement. Discussion of report timing and data ensued. A consensus formed around the data being reported at the end of the third quarter and available by December.

G. Vote on Agreement language - With above changes made
Motion to adopt: Dr. Steve Lazoritz, 2nd: Dr. Deb Esser, Motion adopted unanimously.

H. Other communication

Margaret – A brief summary of the Milbank Memorial Fund meeting attended by Margaret Buck and Margaret Brockman.

Dr. Steve Lazoritz proposed subcommittee to find/create the home for the PCMH Participation Agreement, or to continue to discuss this topic among this group. Agenda item for the next meeting.

Margaret - Communication from Dr. Bob Wergin regarding CMS standard quality measures. Agenda item for the next meeting.

I. Tentative next meeting date for agreement signing: Friday, December 4, 2015

- Extend meeting to discuss the future of PCMH
- Possibly hold meeting in morning (9 am) due to Dr. Lazoritz, and potentially other physicians in Omaha, conflict.

The meeting adjourned at 3:16 p.m.

Adult quality measures menu for 2016 Nebraska Patient Centered Medical Home agreement

Scheduled to be approved at November 16, 2015 Stakeholder meeting for 2016, 2017 Agreement

CMS Shared Savings/ACO Measure Title	NQF Measure/Steward	HEDIS	Source
Domain: Patient Caregiver Experience:			
Getting Timely Care, Appointments, and Information	ACO 1 -NQF #0005 - AHRQ	CAHPS	Survey
How Well Your Providers Communicate	ACO 2 - NQF#0005 – AHRQ	CAHPS	Survey
Patient's Rating of Provider	ACO 3 - NQF#0005 - AHRQ	CAHPS	Survey
Domain: Care Coordination/patient safety			
Risk Standardized, All Condition Readmission	ACO 8 – NQF#1789 - CMS		Claims
Ambulatory Sensitive Conditions Admissions:			
- COPD/Asthma in Older Adults	ACO 9 – NQF#0275 - AHRQ		Claims
- Heart Failure	ACO 10 – NQF#0277 - AHRQ		Claims
Documentation of current medications	ACO 39 – NQF#0419 – CMS	MPM	EHR
Domain: Preventive Health			
Breast Cancer Screening, Mammography	ACO 20 – PREV 5/MSSP	BCS	EHR
Colorectal Cancer Screening	ACO 19 - NQF#0034–NCQA	COL	EHR
Influenza Immunization	ACO 14 - NQF#0041-AMA/PCPI	FVA/FVO	EHR/Survey
Pneumococcal Vaccination	ACO 15 - NQF#0043 – NCQA	PNU	EHR/Survey
BMI screening and follow Up	ACO 16 - NQF#0421 - CMS	ABA	EHR
Tobacco Use: Screening & Cessation Intervention	ACO 17 - NQF#0028 - AMA/PCPI		EHR
High Blood Pressure Control <140/90	ACO 21 - NQF#0018 – NCQA	CBP	EHR
Clinical Depression Screening	ACO 18 - NQF#0418 - CMS		EHR
Domain: At-risk population:			
Diabetes: Hemoglobin A1C poor control	ACO 27 – NQF#3729 – NCQA	CDC	EHR
Diabetes: Eye Exam	ACO 27 – NQF#0055 – NCQA	CDC	EHR
Hypertension: Controlling Blood Pressure	ACO 28 – NQF#0018 – NCQA	CBP	EHR
Ischemic Vascular Disease: Aspirin/Antithrombotic	ACO 30 - NQF#0068 - NCQA		EHR
Heart Failure: Beta-Blocker for LVSD	ACO 31 - NQF#0083 - AMA/PCPI	PBH	EHR
CAD: ACE/ARB for Patients with DM/LVSD	ACO 33 - NQF#0066 - AMA/PCPI	MPM	EHR

Abbreviations: ACO=Accountable Care Organization, NQF=National Quality Forum, AHRQ=Agency for Healthcare Research and Quality, NCQS=National Committee for Quality Assurance, PCPI=Physician Consortium for Performance Improvement, AMA=American Medical Association, MNCM=Minnesota Community Measure, Hedis=Healthcare Effectiveness Data and Information Set

Pediatric Health Outcomes, 2016 PCMH Participation Agreement

Recommended by Subcomittee: Dr. Bob Rauner, Healthy Lincoln, Dr. Deb Esser, Nebraska Blue Cross Blue Shield, Dr. Steve Lazoritz, Arbor Health, Dr. Ken Shaffer, Uninet, Dr. Dale Michels, Lincoln Family Medical Group, Dr. Matha Arun, Aetna, Dr. Michael Horn, United Health Care, Margaret Brockman, Office of Rural Health, Heather Leschinsky, Nebraska Medicaid, Margaret Buck, Senator Mike Gloor's office.

Background FYI: You can pull up each measure on the NQF website: http://www.qualityforum.org/Measures_Reports_Tools.aspx click "NQF endorsed measures" on the left and then type the number in the box to look it up.

Measure Title	NQF Measure/Steward	HEDIS
Domain: Care Coordination/patient safety:		
Documentation of current medications		
Domain: Preventive Health:		
1. Immunizations		
a. Infants (includes Rotavirus and Influenza		HEDIS Combo 9 CIS
b. Adolescents	NQF 1959	IMA
c. HPV	NQF 1959	HPV
2. WCC/Developmental		
a. First 15 months	NQF 1392	W15
b. 3-6 years	NQF 1516	W34
c. Developmental	NQF 1448	
(Examples: ASQ/Ages & Stages, CSBS-DB, MCHAT)		
3. Weight Screening	NQF 0024	WCC
4. Depression: By age 18	NQF 1515	
5. Smoking	NQF 1346	MSC Survey
6. Asthma - (Asthma Action Plan)	NQF 25	
7. Chlamydia Screening for female	NQF 0033	CHL
Domain: At Risk Population:		
1. Depression Screening	NQF 1515	
2. Smoking	NQF 1346	MSC Survey

Prenatal Outcomes Measures
2016 Nebraska PCMH Agreement

Background: You can pull up each measure on the NQF website: http://www.qualityforum.org/Measures_Reports_Tools.aspx click "NQF endorsed measures" on the left and then type the number in the box to look it up.

Measure 1: Prenatal screening using a common state screening form based on the Arbor Obstetric Needs Assessment form (attached).

Measure 2: Non-indicated inducted delivery – NQF 0469

Measure Description:

This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)

PROVIDER INFORMATION

PROVIDER NAME:	MEDICAID ID:
PHONE:	ALTERNATE PHONE:
FORM COMPLETED BY:	

MEMBER INFORMATION

MEMBER NAME:	MEMBER ID / MEDICAID ID #:	
ADDRESS:		
DATE OF BIRTH:	PHONE:	ALT. PHONE:
LANGUAGE PREFERENCE:	SCHEDULED HOSPITAL FOR DELIVERY:	

TOBACCO USE	PRE-PREGNANCY	CURRENT
Average # of cigarettes smoked/day (if none enter 0; 1 pack = 20 cigarettes)		
TOBACCO COUNSELING OFFERED? ☐YES ☐NO		TOBACCO COUNSELING RECEIVED? ☐YES ☐NO
EXPOSURE TO ENVIRONMENTAL SMOKE? ☐YES ☐NO		COUNSELING FOR EXPOSURE TO SMOKE? ☐YES ☐NO

PREGNANCY INFORMATION & HISTORY

DATE OF FIRST PRENATAL VISIT:				17P CANDIDATE: ☐YES ☐NO		
EDC:	by LMP of:	by US Date:	GA at 1st Visit:	Gravida:		
Full Term:				Pre-Term:		
Depression Screen? ☐YES ☐NO				Result: ☐Positive ☐Negative		
Previous AB:	Previous SAB:	Previous TAB:	Living:	Height:	Weight:	BMI:
Last PAP: / /				Last chlamydia Screen: / /		
Dental Visit Last 6 months? ☐YES ☐NO				Dental Referral? ☐YES ☐NO		

ACTIVE MEDICAL CONDITIONS

☐ NO ACTIVE MEDICAL / MENTAL HEALTH CONDITIONS
☐ ASTHMA
☐ CARDIAC DISEASE
☐ CHRONIC HYPERTENSION, PRE-GESTATIONAL
☐ DIABETES, PRE-GESTATIONAL
☐ RENAL DISEASE
☐ OTHER _____

☐ BEHAVIORAL HEALTH CONDITION: _____
☐ SOCIAL, ECONOMIC AND LIFESTYLE ISSUES: _____
☐ SUBSTANCE ABUSE:
☐ ALCOHOL: ☐ DRUG:

Physician Signature #_____

Date Signed:_____

DRAFT

Participation Agreement to recognize and reform payment structures to support Patient Centered Medical Home - 2016

Facilitated by Senator Mike Gloor ~~and Senator John Wightman~~

In ~~2013~~ 2015 we recognize health care delivery and health care insurance is in the upheaval of major reform and health care will endure ongoing transformation in both the public and private markets. This agreement is recognized as only pertaining to Patient Centered Medical Home as defined and agreed upon in this document.

The goal of both health care providers and health insurers participating in this agreement is to reform the delivery of health care services in order to improve the overall health of individual patients, patient populations, to promote an improved consumer experience, and to control or reduce expenditures through appropriate, evidence based, comprehensive care.

We, the undersigned insurance companies and physicians/health care providers agree to support and promote the creation of Patient Centered Medical Homes (PCMH) in Nebraska by using consistent requirements and measurements to promote the efficient transformation of primary care practices into patient-centered medical homes.

The effective date of this agreement is January 1, ~~2014~~ 2016 through ~~January~~ December 31, ~~2016~~ 2017. ~~Insurers will have active PCMH contracts with approximately 10 clinics by the end of 2014 and approximately 20 clinics by the end of 2015. Insurers with contracts covering only a subset of the state's geography would have a number of clinics approximating the percentage of the state's population they reach in the counties they cover (e.g., if their geographic coverage area encompasses 40% of the state's population, they would have 4 clinics per year).~~ All parties agree to work in good faith toward compliance and fulfillment of this agreement.

Definition: In Nebraska, a patient centered medical home, or PCMH, is defined as a health care delivery model in which a patient establishes an ongoing relationship with a ~~physician directed~~ primary care practice team to provide comprehensive, accessible, and continuous evidence-based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality, safety, access and health outcomes in a cost effective manner.

In the event that a health insurer, as part of their PCMH program, requires that a PCMH be certified or recognized as such, or to attain certification or recognition, insurers will accept the following standards:

- NCQA PCMH certification
- JACO PCMH certification
- Nebraska Medicaid PCMH Pilot Program, Tier I and II standards
- URAC certification

In the event that a health insurer, as part of their PCMH program, requires that a PCMH clinic submit clinical measures to determine clinical outcomes, the measures will be selected from those listed in the following charts:

- Adult Health Outcomes (see attached chart)
- Pediatric Health Outcomes (see attached chart)
- Prenatal ~~Care~~ Health Outcomes
- Prenatal Intake Form

Health insurers have the option to use measures for their PCMH program outside of these clinical measures as long as they are clearly communicated, agreed upon by providers, and do not require the PCMH clinics to submit data.

Payment: Insurers offering a medical home program must utilize payment mechanisms that recognize value beyond the fee-for-service payment. Payments should be linked to clinical, financial and/or patient satisfaction measures in accordance with the goals of the Patient Centered Medical Home. Payments shall be directed toward the clinic's full covered panel of patients and not confined to a subset of diseases. The design and details of the payment mechanism will be left up to each individual health plan to determine through an agreement with the provider or provider group to be negotiated in accordance with theis PCMH Participation Agreement ~~program cycle~~.

Nothing in this agreement shall guarantee that a clinic is included in an insurer's PCMH program by meeting the basic criteria. Nothing in this agreement shall preclude the development of alternative innovative models by an insurer for its group and/or individual policies, or alternative models and payment mechanisms to support PCMH.

Progress Report: Participating payers are asked to report annually, by letter, successes realized and challenges faced in their efforts to comply with this agreement. The report should include the number of PCMH contracts signed and give a list of clinics by name, location, number of providers, number of patients covered and may include aggregate financial or health data that comply with the anti-trust statement governing this collaboration (attached).

Date of Signing: December ~~18, 2013~~ 4, 2015
Participants: Please sign with name and title.

_____

Senator Mike Gloor

_____

Senator ~~John Wightman~~ Sue Crawford

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Senator ~~John Wightman~~ Mark Kolterman

_____

Blue Cross Blue Shield of Nebraska

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Nebraska Academy of Family Physicians

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~~Coventry~~ Aetna Better Health of Nebraska

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Nebraska Medical Association

_____

Arbor Health Plan

_____

Nebraska Academy of Pediatrics

_____

UnitedHealthcare

_____

Others?

Multi-Payer Medical Home Antitrust Guidelines for Meetings

1. Set an agenda for each meeting and focus your conversation on the agenda topics. Do not let the conversation wander into subjects that have antitrust sensitivity.

2. The agenda may include discussions and joint decisions on the elements of the PCMH structure, including what services physician practices will be asked to perform as medical homes.

3. Participants may not discuss how to set reimbursement for PCMH services or how much will be paid for PCMH services. However, program elements related to reimbursement that are essential to execution of the program may be discussed and agreed upon.

4. Competitively sensitive and confidential information (e.g. provider fee schedules, payers' market shares, premiums, or marketing plans being developed) may not be discussed.

5. Providers and other participants in the meetings may not discuss how much they want to be reimbursed for their services.

MEMO

Date: November 12, 2015

Re: Discussion of PCMH definition/eligibility

NCQA – allows NPs and PAs as well as physicians to be considered a clinician for certification purposes but the certification comes at a clinic level. Their eligibility guidelines state that if the lead clinician is not a physician, the clinic still has to meet the same standards.

JACO (Joint Commission) – accreditation/certification is more system oriented (mostly hospitals, ACOs and integrated care networks) through patient safety initiatives.

URAC's information was much like JACOs,

Nebraska Medicaid – New RFP will allow NPs to be PCMH lead.

Medicare Pilot Programs (CPCI, MAPCP) – no consistent definition across pilots. Some specifically allow NPs and PAs as leads, some don't specifically mention it but in practice allow it. To my knowledge, none specifically prohibit it.

BCBS of Michigan PCMH program defines PCMH as a physician lead primary care practice.

Oklahoma Sooner Care lists ARNPs on their provider list of PCMH providers. They use "primary care practice" in their definition language.

Minnesota Department of Health "Health Home" providers include NPs. They use "physician practice" language in promotional materials.

Louisiana: "Primary care providers are inclusive of physician-led and nurse-practitioner-led primary care practices"

NM: "Chapter 143 of the 2009 Laws specifies that medical doctors, physician assistants, and nurse practitioners are eligible for recognition as offering medical homes."

Illinois requires PCP in their medical home pilot program to have admitting and delivery privileges at a local hospital. (Does this limit to physicians?)

Iowa requires NCQA certification, or an equivalent such as JACO, and uses "provider" language.

Kansas uses the language "physician or other personal care provider in a physician-directed team."

Maine requires NCQA certification.

November 5, 6 2015 Milbank Memorial Fund meeting, Detroit
Margaret Buck, Margaret Brockman attended.

Because Nebraska has a multi-payer PCMH agreement, we are part of a learning collaborative sponsored by the MMF. The collaborative includes the 8 states with a federally funded program plus Montana and Nebraska. Montana's program is now part of their Department of Insurance through statute.

At this meeting we interacted with representative of CMS (Center for Medicare and Medicaid Systems) and representatives from Mathematic, the contractor involved in evaluating the 8 federal contract programs. Mathematic presented information on what they see in the initial evaluations and how to improve the future reports and evaluations. The CMS representative spoke to the evaluations, opportunities for improvement in the programs and evaluations and to the possible future of the programs. Although we are not one of the 8 federal grant states, their success has a huge impact on our work and it gives us information opportunities for us to join any future expansion of the programs.

We also discussed the progress of some of the state level programs – Arkansas, Colorado and Vermont.

The last few hours of the meeting were dedicated to brainstorming the future of this collaborative and how MMF can be of assistance to the involved states.

Overall, much information is shared and contacts made. Although our private agreement is unusual in this group it is considered no less valid or important. In fact, the comment was made to me that they expect to see more agreements such as ours in the future from other states.

Some take aways:

A neutral convener for aggregating data and savings calculation is necessary for removing barriers for rural providers to participate as well as community resources such as shared care managers.

Oklahoma has a 3rd part convener we need to learn more about.

A key principle for the Colorado Green Mountain program: Upfront investment, over a reasonable amount of time, then redistribution of total spending toward demonstrated sources of value.

Form of payment matters as much as level of payment.

PCMH "effect" becomes apparent in year 4 according to a private insurance company study.

One way to approach policy makers about PCMH reform is to articulate what will happen if we don't do this.

Multi-payer patient-centered medical home stakeholder group

Senator Mike Gloor

Meeting date: Friday, October 2, 2015, 1:30 to 3:30 p.m.

Meeting place: ***Room 1524***, State Capitol Building, Lincoln, Nebraska

Conference Access Number: **(888) 820-1398;** Attendee Code: 7443929#

Agenda

A. Welcome & introductions

B. Anti-trust statement

C. Presentation on Community Health Workers by Pat Lopez, Public Health Districts

D. Health outcome measures/Medicaid standards sub-committee progress report

E. Presentation and discussion of ideas for changes in Participation Agreement

F. Information sharing

   a. Map of clinics

   b. SERPA recognition by Medicare Shared Savings

   c. Medicaid Managed Care RFP

   d. Other items of interest – US HHS grant announcement for PTN/SAN, Iowa Health Care Collaborative includes Nebraska

G. Set next meeting date and time

Note: For discussion of the participation agreement language please come prepared with changes you'd like to see. Some of my questions are:
Do we want to keep the time frame at 2 years?
Do we want more than a letter for a reporting mechanism – can we can use it to promote PCMH. The previous reports were made public on Senator Gloor's webpage and will be part of a report to the Committees named in the Legislative study resolution. One thing I am repeatedly asked for when talking to an employer or to state employee benefits is an indication of prevalence - number of clinics and location. Is this PCMH concept big enough yet to garner their support or benefit their employees? Should we think about a way to incorporate support of employer? (in case we manage to land some)
I will bring a new draft of what we talked about at the last meeting that we can work from.